Billing and Coding Guidelines for Radiation Oncology Including Intensity Modulated Radiation Therapy (IMRT)

LCD Determination ID Number
L30316

Guidelines

Reasons for Denial
Services performed for diagnoses not listed as covered in this policy or for excessive frequency will be denied as not medically necessary. Frequency is considered excessive when services are performed more frequently than generally accepted by peers and the reason for additional services is not justified by documentation.

Services not listed as covered under the "Indications, Limitations of Coverage and/or Medical Necessity" section above will be denied as not medically necessary.

When a hospital inpatient is transported to a freestanding facility for therapy, the technical component of the radiation oncology services cannot be paid to the freestanding facility. Unless the patient is discharged from the hospital and treated at the freestanding facility as an outpatient, this payment will be denied.

Appeals for denied claims must be accompanied by that portion of the patient's medical record that documents the reason for the service. It is not necessary to provide the complete medical record.
Note: All documentation must be specific to the patient being treated or the claim will be denied.

Radiation - General

A. *Radiation physics services (CPT codes 77300-77334, 77399) include a professional component (PC) and a technical component (TC). These services are covered following the same logic as other radiologic services that include PC and TC components.*

1. *The physician's professional component is covered in all settings when the billed service represents the physician's (e.g., radiologist, radiation oncologist) involvement in the care. Radiation dosimetry calculations are payable by Medicare Part B only when the physician personally performs the service described in the code, or when the physician participated in the provision of the service (e.g., reviewed or validated the physicist's calculation).*

2. The technical component is covered only in settings where the TC is payable (e.g., freestanding clinic). The services provided by a Radiation Physicist are considered a part of the TC.
When the radiation physics service is provided in a hospital setting, it is considered a Part A service, therefore, is not billable to Part B. This is true whether the physicist is employed by a radiologist, or is employed by, or under contract with, the hospital. Therefore, Physicists may <u>not</u>:
-direct bill for their services,
-submit "incident to" billing for services furnished to hospital inpatients or outpatients, or
-receive duplicate payment for the same services furnished by a radiation oncologist.

3. *When the radiation physics service is provided in a freestanding clinic, the physicist's services are included in the global service billed by the physician.*

B. Radiation physics services (CPT codes 77336, 77370) are technical services only. These services are covered only in settings in which the technical component is payable (e.g., freestanding clinic).

C. ICD-9 codes must be used to the highest level of specificity.

D. The following services are bundled into the radiation therapy codes:
11920,11921,11922,16000,16010,16015,16020,16025,16030,36425,
53670,53675,99211,99212,99213,99214,99215,99238,99281,99282,
99283,99284,99285,90780,90781,90841,90843,90844,90847,99050,
99052,99054,99058,99071,99090,99150,99151,99180,99182,99185,
99371, 99372, 99373
Anesthesia (whatever code billed)
Care of infected skin (whatever code billed)
Checking of treatment charts, verification of dosage, as needed (whatever code billed)
Continued patient evaluation, examination, written progress notes, as needed (whatever code billed)
Final physical examination (whatever code billed)
Medical prescription writing (whatever code billed)
Nutritional counseling (whatever code billed)
Pain management (whatever code billed)
Review & revision of treatment plan (whatever code billed)
Routine medical management of unrelated problem (whatever code billed)
Special care of ostomy (whatever code billed)
Written reports, progress notes (whatever code billed)
Follow-up examination and care for 90 days after last treatment (whatever code billed)

Please consult the latest version of Correct Coding Initiative (CCI) for rebundling combinations.

E. For Treatment Devices, Designs, and Construction (CPT codes 77332-77334). The number of different anatomic sites determines the number of sets or ports involved except opposing fields (such as AP/PA) which represent one set. Each set must be submitted on the claim, with the appropriate level of complexity at the onset of therapy or as appropriate when additional devices are implemented during a course of treatment.

F. Place of Service:
Payment is limited to services furnished in office (POS 11), inpatient hospital (POS 21), and outpatient hospital (POS 22). A freestanding radiation oncology center is considered, for billing purposes, an office.

G. Refer to the individual sections of this policy for further clarification and coding guidelines.

H. **CPT 77427 - Radiation treatment management represents a physician's professional services**. Reimbursement of one unit represents five consecutive fractions or treatment sessions regardless of the number of days during which these treatments are administered.

Each unit of service (5 treatment sessions/fractions) of radiation therapy management should be billed on a separate claim line and should be billed with (1) one unit of service in Item 24G of the

CMS-1500 claim form or the electronic equivalent. The date of the last treatment session/fraction should be entered as the date of service.

Documentation needs to include the date and the current treatment dose on the day of the weekly management note, although the individual components of the service may occur throughout the reporting period. A radiation oncologist must evaluate the clinical and technical aspects of the treatment and document that evaluation and the resulting management decisions.

The number of treatment sessions/fractions being billed for must be indicated in Item 19 of the CMS-1500 claim form or the electronic equivalent.

If more than one treatment session/fraction is performed on the same date of service (AM and PM), place this information in Item 19 of the CMS-1500 claim form or the electronic equivalent.

IMRT

IMRT Treatment Planning
CPT code 77301 *Intensity Modulated Radiation Therapy (IMRT) plan, including dose-volume histograms for target and critical structure partial tolerance specifications.*
(Dose plan is optimized using inverse or forward planning technique for modulated beam delivery (e.g., binary dynamic MLC) to create highly conformal dose distribution. Computer plan distribution must be verified for positional accuracy based on dosimetry verification of the intensity map with verification of treatment set-up and interpretation of verification methodology)
This code is typically reported only once per course of IMRT.

IMRT Treatment Delivery
Collimator-based IMRT Treatment Delivery
CPT/HCPCS code G6015 *Intensity Modulated Radiation Therapy (IMRT) delivery, single or multiple fields/arcs, via narrow spatially and temporally modulated beams, binary, dynamic MLC, per treatment session*

Compensator-based IMRT Treatment Delivery
CPT/HCPCS code G6016 *Compensator-based beam modulation treatment delivery of inverse planned treatment using three or more high resolution (milled or cast) compensator convergent beam modulated fields, per treatment session*

Medical Radiation Physics, Dosimetry and Treatment Devices for use with IMRT
Basic Radiation Dosimetry
Basic radiation dosimetry is a separate and distinct service from IMRT planning and should be reported accordingly. The radiation dose delivered by each IMRT beam must be individually calculated and verified before the course of radiation treatment begins. Thus, multiple basic dosimetry calculations (up to 10) are typically performed and reported on in a single day. Supporting documentation should accompany a claim for more than ten (10) calculations in a single day.

IMRT Dosimetry
CPT code 77300 *radiation therapy dose plan*

Treatment Devices

There are several categories of treatment devices used in conjunction with the delivery of IMRT radiotherapy. Immobilization treatment devices are commonly employed to ensure that the beam is accurately on target. In addition, the radiation oncologist is responsible for the design of the series of treatment devices that define the beam geometry. The beam aperture, the dose constraints per beam, the couch and gantry angles for each portal, and the coverage requirements all must be evaluated in order to guide the generation of the multi-leaf collimator segments. It is appropriate to report a treatment device CPT code for each complex IMRT field (i.e., gantry/table angle for step and shoot and sliding windows). It should not be billed for each segment within the field. CPT code 77334 is typically billed multiple times (often on the same day of service), once for each of the separate IMRT fields as required by the plan during the course of IMRT treatment. The typical case will require up to ten (10) devices. A claim for the use of more than ten (10) should be submitted with supporting documentation.

CPT codes for IMRT Treatment Devices

77332 treatment devices, design and construction; simple
77333 treatment devices, design and construction; intermediate
77334 treatment devices, design and construction; complex

Devices

CPT code 77338 Multi-Leaf Collimator (Mlc) device(s) For Intensity Modulated Radiation Therapy (IMRT), design and construction per IMRT plan. Do not report 77338 more than once per IMRT plan. Do not report 77338 in conjunction with G6016, compensator based IMRT.

G6016 Compensator-based beam modulation treatment delivery of inverse planned treatment using 3 or more high resolution (milled or cast) compensator convergent beam modulated fields, per treatment session. For treatment planning, use 77301. Do not report G6016 in conjunction with 77401, G6003-G6014 or G6015.

Image Guided Radiation Therapy
Image Guided Radiation Therapy (IGRT) utilizes imaging technology to modify treatment delivery to account for changes in the position of the intended target. IGRT is used in conjunction with IMRT in patients whose tumors are located near or within critical structures and/or in tissue with inherent setup variation. Although an IGRT is a distinct service, it may be used and documented along with IMRT treatment delivery (G6015) when necessary.

CPT codes for IGRT

G6001	Ultrasonic guidance for placement of radiation therapy fields
77014	Computed tomography guidance for placement of radiation therapy fields
G6002	Stereoscopic X-ray guidance for localization of target volume for the delivery of radiation therapy
G6017	Intra-fraction localization and tracking of target or patient motion during delivery of radiation therapy(e.g.,3-D positional tracking, gating, 3-D surface tracking), each fraction of treatment

Bundling
CMS CCI edits will apply to radiation codes and may include the following:

The following CPT codes were used as *building blocks* during the development of the IMRT planning CPT code. They are components of CPT code 77301 and therefore should not be separately coded or billed on the same day of service.

CPT Code	CPT Code Descriptor
76370 / 77014 (deleted/current)	Computerized axial tomography guidance for placement of radiation therapy fields
76375/ 76376 (deleted/current)	Coronal, sagittal, multiplanar, oblique, three-dimensional and/or holographic reconstruction of computerized axial tomography, magnetic resonance imaging, or other tomography modality
77295	Therapeutic radiology simulation-aided field setting; Three-dimensional simulation
77331	Special radiation dosimetry

The following list of codes should not be reported on the *same date of service* as IMRT planning (77301). They may, however, correctly be used, as needed, for medically necessary simulation and treatment planning during the course of IMRT treatment (i.e. with code G6015).

CPT Code	CPT Code Descriptor
77280	Therapeutic radiology simulation-aided field setting, simple
77285	Therapeutic radiology simulation-aided field setting, intermediate
77290	Therapeutic radiology simulation-aided field setting, complex

Summary of 2015 coding changes:
CMS established HCPCS level II "G" codes for use in 2015. The G codes are recognized under the Medicare Physicians Fee Schedule (MPFS) but are not recognized under OPPS.

Radiation treatment delivery: G codes G6003-G6014 will be used in the MPFS and CPT codes 77402, 77407, and 77412 will be used in OPPS.

IMRT: G codes G6015 and G6016 are used for payment under the MPFS and CPT codes 77385 and 77386 will be used in OPPS.

Isodose Planning codes: CPT codes 77305-77315 were deleted and replaced by codes 77306 and 77307 CPT code 77300 should not be reported with these codes.

Image Guided Radiation Therapy (IGRT): CPT codes 76950, 77421 and 0197T were deleted and replaced with G6001, G6002 and G6017 for MPFS and CPT 77387 for OPPS, the details of the bundling of the TC or PC can be found in the CPT manual.

Submitting Documentation:

Part A
Do not attach information to the original claim. Below is the list from the Part A website of what documentation is requested when reviewing radiation therapy:

Radiation Therapy
A detailed itemization and supporting documentation for all services billed
Documentation of history of illness being treated
Documentation of physician involvement
Physician order(s) for treatment including current dosage

• Documentation to support all services billed were provided
    o Dosimetry reports
    o Physicist reports
    o Simulation reports
    o Oncology reports

Documentation of each treatment billed
Copy of radiological report or physician's interpretation
Documentation of any contrast material provided

Part B.
Do not attach information to the original claim.
Additional information can be placed in Item 19 on the 1500 form or its electronic equivalent when needed.

Original Determination Effective Date
08/16/2009

Revision Effective Date
02/01/2015

Revision History
02/01/2015 CPT/HCPCS code update effective 01/01/2015: added codes 77385 and 77386. This was missed in the revision history below dated 01/01/2015.

01/01/2015 CPT/HCPCS code update effective 01/01/2015: removed codes 77305, 77310, 77315, 77326, 77327, 77328, 77402-77416, 77418, 77421, 76950, 0197T, 0073T and associated instructions, Added codes 77306, 77307, G6001-G6017.

11/01/2014 Annual review completed 10/09/14.

01/01/2014 Clarification added for CPT 77427.

10/01/2013 Annual review completed on 09/09/2013 with formatting update, no change to policy. CMS National Coverage Policy citing moved from Billing and Coding Guidelines into policy.

12/01/2012 Added clarification for billing and coding CPT 77427.

Start Date of Notice Period
12/01/2012, 12/01/2011; 07/01/2011; 01/01/2010; 07/01/2009